## ATTACHMENT 6

Check One: _____ initial request _____ first reauthorization
_____ second authorization _____ subsequent reauthorization

MAIL TO:

EDS
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/CADTA

1. Complete this form.
2. Attach PA/RF.
3. Attach all requested information.
4. Attach prescription.
5. Mail to EDS

### PRIOR AUTHORIZATION
### CHILD/ADOLESCENT DAY TREATMENT

Providers should carefully read the attached instructions before completing this form.

SECTION I.

RECIPIENT INFORMATION

| (1) Last Name | (2) First Name | (3) MI | (4) Medical Assistance Identification # | (5) Age |
|---|---|---|---|---|
| Patient | Is | A | 1234567890 | 16 |

PROVIDER INFORMATION

| (6) Day Treatment Provider Name | (7) Medical Assistance Provider # | (8) Name and Phone Number of Contact Person |
|---|---|---|
| DAY TREATMENT PROVIDER | 87654321 | I. M. DIRECTOR<br>(xxx) xxx-xxxx |

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(9) Requested start date and end date for this authorization period (if start date is prior to when request will be received at EDS, please indicate clinical rationale).

2/17/92 - 4/24/92
Please backdate. Is was started in program on 2/17 to coincide with her release from inpatient. Multi-agency meeting held on 2/19.

(10) Number of hours of treatment to be provided over prior authorization grant period. Indicate pattern of treatment, e.g., three hours/day, three days per week for eight weeks.

3 hours - 5 days/wk for 10 weeks = 150 hours

SECTION II.
The following additional information must be provided. If you attach copies of existing records to provide the information requested please limit attachments to two pages for the psychiatric evaluation and illness/treatment history Highlighting relevant information is helpful. Do not attach M-Team summaries, additional social service reports, court reports, or other similar documents unless directed to do so following initial review of the documentation.

A. Present a summary of the recipient's psychiatric assessment and differential diagnosis. Diagnoses on all five axes of DSM-III-R are required. If not conducted by a psychiatrist, a psychiatrist must review and sign the summary and diagnoses.

(Summarized from admission statement)

Patient is a 16 year old female who is admitted for her second psychiatric hospitalization in less than six months. Her chief complaints are "I have a drug problem...my life's a mess and I don't know how to fix it". Her admission was precipitated when she was involved in an automobile accident in which she was riding with a drunk driver and she herself was drunk. Although there were no serious injuries the accident seemed to scare Is into some acknowledgement of her substance abuse. She has a history of self-inflicted injury, primarily by cutting on herself.

Summary of Past History

She began outpatient therapy in April of 1991 focusing on her depression, irritability, and mood swings. Little seemed to have been accomplished. Her dysfunctioning became more evident at the start of the school year in September 1991 and resulted in her first hospitalization in October. At this time she was diagnosed with bipolar mood disorder and started on Lithium. She remains on Lithium and Prozac was later added to her regimen. There was some improvement noted during the hospitalization and Is and her family participated in the day treatment program for six weeks following discharge. Despite some improvement in communication and expression of feelings, Patient did not acknowledge substance abuse problems at that time. Following discharge from day treatment in mid-December the family discontinued treatment except that Patient sporadically attended aftercare group.

Patient reports depression dating back to early 1990 with complaints of hopelessness and worthlessness, appetite and sleep disturbance and loss of interest in usual activities. Her grades declined significantly during the following school year and she reported difficulty concentrating which may have been related to her increasing use of drugs during that time. Although Patient admits to occasional drinking as early as age 12, significant usage did not begin until 1990 (see attached substance abuse assessment).

Summary of Family History, Development, Medical

Is lives with her mother and father and a 10 year old brother. The family history is significant for the lack of any outstanding psychopathology. Mother reports a normal development. Patient has no known allergies or medical problems.

Examination Findings

Patient presents as a normally developed female for her age. She did appear very run down and reports that she had been drinking and smoking pot a lot over the past week and not sleeping much. Depression is evident and Patient acknowledges suicidal thinking and planning. (She has considered overdosing on drugs and alcohol.) There was no evidence of hallucinations, delusions, or unusual thinking. Memory is intact. Insight appears limited and is undoubtedly impaired by both her depression and substance abuse.

Impressions

Despite the significant depression and substance abuse, Patient's prognosis is good if her current acknowledgement of her substance abuse can be supported. The family is intact and supportive and is a good asset if they can maintain treatment after the immediate crisis.

(Continued on attached sheet)

Axis I: Major Depression, recurrent, severe
Alcohol and Cannabis abuse

Axis II: Deferred

Axis III: None

Axis IV: 2--arguments with parents, difficulty at school

Axis V: GAF at admission--45, highest GAF past year 55 J. M. Physician

Plan

Admit for stabilization with suicide precautions. Maintain medication regimen. Individual, group, family therapy. AODA treatment. Plan discharge to day treatment when Patient's suicidal ideation has decreased to the point where she can be trusted not to harm herself and there is stabilization in mood, sleep patterns and eating.

B. Present a summary of the recipient's illness/treatment/medication history and other significant background information. Why do you think day treatment will produce positive change?

Patient relates that her depression started in mid-1990. She began superficial cutting later that year and reported that it decreased her anger and pain. She reports sleep disturbance, nightmares, fatigue, and irritability.

She participated in individual and group outpatient counseling in April, 1991. She reportedly had a difficult time expressing feelings or understanding the connection between her feelings and her behavior. She denied any substance abuse problems at that time.

Patient's functioning deteriorated significantly at the start of the next school year. She was engaged in significant conflict with her parents over rules at home and was missing school frequently. She was expressing a wish to die and refused to sign a No Self Harm contract with her outpatient therapist. She was admitted to inpatient care on October 10, 1991. She was diagnosed with Bipolar Mood Disorder and started on Lithium 300 mg t.i.d. An AODA evaluation (see attached) yielded additional diagnoses of alcohol and cannabis abuse.

At discharge, Patient was admitted to day treatment to provide intensive therapy and support during the transition back to school and home. She attended for six weeks and began to express feelings more appropriately and discuss alternative and safe methods of releasing her emotions. Prozac was added because of continued mood swings and depression. The family participated in treatment and there seemed to be some improvement in communication. However, she continued in denial with regard to substance abuse.

Following discharge from day treatment the family discontinued involvement in therapy. She attended aftercare group sporadically. Despite earlier improvement she quickly regressed into complaints about limits at home and school. Parents reported that she began staying out late at night. She was involved in an automobile accident (she was not the driver) that involved alcohol and Patient was intoxicated at the time. Though she was not charged her parents brought her back to the hospital for intervention. She acknowledged that she felt out of control and was admitted back to inpatient care on February 1, 1992. After two weeks inpatient, during which time her condition was stabilized, she was discharged again to day treatment. Both Patient and the family felt that day treatment was important during the transition back to home and school.

Patient's potential for change seems good now that she has acknowledged her substance abuse. The family also seems to understand the need to continue treatment following Patient's discharge from day treatment.

C. Complete the checklist for determination that an individual meets the criteria for severe emotional disturbance (SED). Criteria for meeting the functional symptoms and impairments are found in the instructions. SED in an individual under the age of 21 requires acute treatment and may lead to institutional care. **The disability must be evidenced by 1, 2, 3 and 4 listed below.**

1. **The individual must meet all three of the following:**
   - [X] a. be under the age of 21, and
   - [X] b. have an emotional disability that has persisted for at least 6 months; and
   - [X] c. that same disability must be expected to persist for a year or longer.

2. **A condition of severe emotional disturbance** as defined by a mental or emotional disturbance listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, III, Revised (DSM III-R).

   [X] 296.33 Major Depression; 305.00 Alcohol Abuse; 305.20 Cannabis Abuse
   Primary Diagnosis

3. **Functional Symptoms and Impairments**
   The individual must have A. or B.

   a. **Symptoms** (must have one)
      - [ ] 1. Psychotic symptoms
      - [ ] 2. Suicidality
      - [ ] 3. Violence

   b. **Functional impairments** (must have two)
      - [ ] 1. Functioning in self care
      - [ ] 2. Functioning in the community
      - [ ] 3. Functioning in social relationships
      - [X] 4. Functioning in the family
      - [X] 5. Functioning at school/work

4. **The individual is receiving services from two or more of the following service systems.**
   - [X] Mental Health
   - [ ] Social Services
   - [ ] Child Protective Services
   - [ ] Juvenile Justice
   - [X] Special Education

**Eligibility Criteria Waived Under Certain Circumstances:**

[ ] This individual would otherwise meet the definition of SED, but has not yet received services from more than one system, but would be likely to do so were the intensity of treatment requested not provided. Attach explanation.

[ ] This individual would otherwise meet the definition of SED except that functional impairment has not persisted for six months, but the nature of the acute episode is such that impairment in functioning is likely to be evident without the intensity of treatment requested. Attach explanation.

D. Describe the treatment program which will be provided. Attach a day treatment program schedule. Summarize the proposed intervention in this section. The treatment plan should specify how program components relate to this specific client's treatment goals.

**Patient is to attend day treatment four hours a day, five days per week. Part of this time will not be billed to MA because it is used for educationally related work and recreation. We will use groups led by a psychiatric nurse to work with Is on the identification and expression of feelings (see treatment plan) and groups led by an AODA counselor to improve her understanding of her substance abuse. The family will attend the multiple-family group one time per week and will meet with staff individually once per week to focus on family understanding of both the emotional issues and the substance abuse. These family meetings will be led by our psychologist. A program schedule is attached.**

E. Indicate the rationale for day treatment. Elaborate on this choice where prior outpatient (clinic) treatment is absent or limited. Why does the recipient need this level of intervention at this time?

**Patient's quick return to the hospital after her first admission demonstrated the necessity for a more intense aftercare plan. Both Patient and her family understand the need to continue outpatient treatment. Her continued mood swings and rather tentative abstinence argue for a fairly intensive level of treatment for the first two months following discharge. Her history also suggests that she would benefit from a high degree of structure. The plan will be to reduce intervention to weekly group therapy for Patient, weekly to biweekly family therapy and AA, NA, and Al Anon meetings.**

F. Indicate the expected date for termination of day treatment. Describe anticipated service needs following completion of day treatment and transition plan.

**Day treatment is expected to terminate on 4/24. Plan is to continue family therapy weekly on an outpatient basis. Is will continue with AA/NA groups. She will also have medication management, as needed.**

SECTION III.
Please attach and label the following:

A. The prior authorization request form (PA/RF).

B. One of the following (check which is attached):

[ ] A copy of the signed and dated HealthCheck referral for day treatment from a physician; or

[X] A copy of the signed and dated HealthCheck referral for day treatment from a provider other than a physician, and a physician's prescription for day treatment, or

[ ] A copy of the signed and dated HealthCheck referral for a psychiatric evaluation/diagnosis if there has not been a differential diagnosis within the past 12 months and a physician's prescription for day treatment, or,

[ ] If there has been a differential diagnosis within the past twelve months, a physician's prescription for day treatment and a copy of the signed and dated HealthCheck referral.

*A copy of the HealthCheck referral must be attached to all requests. For reauthorizations, a copy of the original HealthCheck referral must be attached. The initial request for these services must be received by EDS within six months of when the HealthCheck referral was dated.*

C. A multi-agency treatment plan.

D. A day treatment services treatment plan.

E. Results of either the Achenbach Child Behavior Checklist or the Child and Adolescent Functional Assessment Scale (CAFAS).

F. An AODA assessment may be included. An AODA assessment must be included if AODA related programming is part of the recipient's treatment program.

Patient reports initial alcohol use around age 12 consisting of drinking at parties when alcohol was available--about one time per month. Marijuana use began about one year later and was also sporadic initially. Prior to her admission to the hospital she reports use of alcohol and/or drugs three to four times per week. Alcohol use is generally limited to beer, about six cans when she is drinking, but she reports occasional use of whiskey. She reports that she loves to smoke pot and would smoke it daily if she could, but her use is limited to how often she can get it. Use of other drugs appears to be fairly limited. She reports trying speed once and using some inhalant, but she reports that she did not like these drugs. She says she uses drugs and alcohol as a way to socialize and feel happy.

She reports blackouts and becoming physically sick on occasion. She reports drinking when she skips school and coming to school drunk or high on a number of occasions. She reports poorer grades and decreased recreational activities (she used to be involved in piano lessons and creative dance, but has dropped these activities) although the relationship between these changes and her substance abuse is not clear. Her activities with friends have become limited to those involving drugs or alcohol and she reports that she is spending more time with people who are heavy users. She seems to see that she often feels worse after use of drugs or alcohol, both physically and emotionally, but minimizes the fact that this does not prevent her from changing her use. She says that she can make choices about avoiding use, but her ability to make consistent healthy choices does not appear to be supported by her drug use history. She reports that she has abstained from use of either drugs or alcohol for periods of up to two weeks.

Patient describes her parents as social drinkers. She identifies an aunt as having been in AODA treatment. She reports that her relationship with her parents has been conflictual over issues of rules at home, when she has to be in, etc. She says she gets along OK with her brother.

A diagnosis of alcohol and cannabis abuse is supported by Is's history of alcohol and marijuana use, her use during school, the decline in school attendance and performance, the decreased recreational activities other than substance use, the presence of blackouts on occasion, and her expressed interest in using marijuana daily if it were available.

*I attest to the accuracy of the information on this prior authorization request.*

J. M. Director — 2/21/92

Signature of Day Treatment Program Director — Date

APPENDIX 32

WMAP HEALTHCHECK/EPSDT REFERRAL FORM

DATE OF SCREENING: 2/14/92

RECIPIENT NAME: Is Patient MA-ID # 1234567890

DATE OF REFERRAL APPOINTMENT: 2/14/92

REASON FOR REFERRAL: Mental Health and General Health Concerns

REFERRED TO: Day Treatment

Provider Name, Address, and/or Specialty

COMMENTS: Just hospitalized for depression/substance abuse. Appears to require follow-up. No other significant findings.

SIGNATURE: J. M. Screener DATE: 2/14/92
Screening Provider

NOTE: This form is acceptable in lieu of the WMAP HealthCheck (EPSDT) Services claim form when it is used as a referral form.

MAPB-092-001-Z
October 19, 1992

Prescription for Day Treatment

I have examined the following individual and their medical record:

**Is Patient**
name

**609 Willow, Anytown**
address

**1234567890**
medical assistance identification number

I find **Is Patient** to be appropriate for day treatment for severe emotional disturbance. Services are expected to be required for up to **6 months**.

I M. Provider, Psychiatrist

**22 N. Maple, Anytown**
Address

**12345678**
UPIN/Medical Assistance Provider Number

**2/17/92**
Date

Department of Health and Social Services
Division of Community Services
Office of Mental Health
March 20, 1992

STATE OF WISCONSIN

## MODEL PLAN: INTENSIVE IN-HOME PSYCHOTHERAPY OR DAY TREATMENT

| **Name of Client:** Is Patient | Agency Team Developing and Implementing this Plan (include title indicating discipline): |
|---|---|
| **Client Birthdate:** 7/15/75 | 1. I.M. Primary, RN (program coordinator) |
| **Date of Plan: 2/19/92** | 2. I.M. Manager, O.T. |
| **Plan review date:** 8/92 | 3. I.M. Doctor, Ph.D. |
| **Case Manager:** I.M. Manager, OT | 4. I.M. Artsie, A.T. |
| **List family members involved in treatment:** | 5. |
| 1. Be Patient, Father | 6. |
| 2. Was Patient, Mother | 7. |
| 3. Not Patient, Brother | 8. |
| 4. | |
| 5. | |
| 6. | |
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| **Problem 1:** | **Short Term Goal (measurable):** |
|---|---|
| Alcohol and Drug Abuse | Abstain from alcohol and drugs. Is will attend day treatment groups and 2 AA/NA/Alateen |
| | meetings per week. Is will be able to identify the definition of substance abuse and how it |
| | applies to her. |
| **Description of Problem:** | **Long Term Goal (measurable):** |
| Patient is using alcohol and/or drugs | Continued abstinence from alcohol and drugs (per Is's report and parents description of her |
| 3-4 times per week, has exhibited | behaviors). Acknowledgement of her addiction and understanding of the addiction process. |
| decreased school attendance and | Reintroduction of recreational activities which are non-drug and alcohol related. |
| grades, reports blackouts and | **Plan (include frequency of intervention and team member responsible):** |
| potentially dangerous situations | Group and individual sessions 5 X wk. with AODA counselor to learn didactics of substance abuse, |
| related to her substance abuse. She | understand how they apply to her and address other issues related to substance abuse. |
| reports a desire to quit but does not | |
| demonstrate insight into her | |
| addiction. | |
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| | **Measurable Results of Intervention at Time of Plan Review:** |
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| **Problem 2:** | **Short Term Goal (measurable);** |
|---|---|
| Depression, mood swings, self- | Discuss feelings in group 3 X wk. Identify three situations which lead to self destructive behavior and |
| mutilation | three healthy responses. |
| | |
| **Description of the Problem:** | **Long Term Measurable Goal (measurable):** |
| Is has a difficult time | Is will be able to initiate discussions about feelings with parents and therapists. Is will not |
| identifying and expressing feelings. | engage in self destructive behaviors. Is will demonstrate decreased mood swings by self report |
| She acts on feelings, often in | and parents report. |
| destructive ways such as cutting | **Plan (include frequency of intervention and team member(s) responsible):** |
| herself and substance use. She has a | Group psychotherapy 5 X wk. with psychiatric nurse/OT; family therapy weekly with Ph.D.; multiple |
| difficult time initiating interactions | family therapy group weekly with Ph.D. M.D. will monitor psychotropic medications and adjust as |
| with family and friends and has a | needed. |
| hard time accepting criticism. | |
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| | **Measurable Results of Intervention at Time of Plan Review:** |
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| **Problem 3:** | **Short Term Goal (measurable):** |
|---|---|
| Impaired Family Relations | Family will identify three limits that need to exist at home and how to manage them. Parents will |
| | understand definition of substance abuse and how it applies to Is. |
| | |
| | **Long Term Goal (measurable):** |
| | Parents will understand nature of the addiction process and their role in recovery for Is. |
| **Description of the Problem:** | Family will be able to discuss feelings and argue without resort to destructive communication |
| Is's relationship with her parents | patterns. |
| has been increasingly conflictual over | **Plan (include frequency of intervention and team member(s) responsible):** |
| the past two years. Some gains were | Family therapy weekly; Multiple family group weekly with Ph.D. |
| made during last hospitalization but | Is will use other groups and 1:1 time to process feelings about family. |
| parents admit to not trusting Is | |
| right now. Is has difficulty | |
| accepting limits at home and in | |
| knowing how to talk about this with | |
| parents. Parents do not understand | **Measurable Results of Intervention at Time of Plan Review:** |
| substance abuse/addiction though they | |
| are supportive of treatment. | |

| **Problem 4:** | **Short Term Goal:** |
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| | **Long Term Goal:** |
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| | **Plan (include frequency of intervention and team member(s) responsible):** |
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| | **Measurable Results of Intervention at Time of Plan Review:** |
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| **Problem 5:** | **Short Term Goal:** |
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| | **Long Term Goal:** |
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| | **Plan (include frequency of intervention and team member(s) responsible** |
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| | **Measurable Results of Intervention at Time of Plan Review:** |
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| **Program Discharge Criteria:** |
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| Is will be able to identify and express feelings more appropriately. Is will be able to enter into a 'no self harm' contract. Is will |
| have a regular/consistent recovery program. Is and family will show ability to discuss limits and problems and commit themselves to |
| continued outpatient therapy. |
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D. M. Prowder
**Psychiatrist's Signature**

MM/DD/YY
**Date**

*file = Service\TxPlan [E,green]*

## DAY TREATMENT PROGRAM

### Daily Schedule

<table>
<tr><th>Time</th><th>Monday</th><th>Tuesday</th><th>Wednesday</th><th>Thursday</th><th>Friday</th></tr>
<tr><td>2:00</td><td colspan="5">Check-In ----------→</td></tr>
<tr><td>2:15</td><td colspan="2" rowspan="2">Group Therapy</td><td>Group Therapy</td><td colspan="2" rowspan="2">Group Therapy</td></tr>
<tr><td>3:15</td><td rowspan="4">Special Recreation Activity</td></tr>
<tr><td>3:45</td><td colspan="2">Break and Homework</td><td colspan="2">Break and Homework</td></tr>
<tr><td>4:15</td><td rowspan="2">O.T. Group</td><td rowspan="2">Issues Group</td><td rowspan="2">Issues Group</td><td rowspan="2">O.T. Group</td></tr>
<tr><td>5:00</td><td rowspan="2">Dinner</td></tr>
<tr><td>5:45</td><td colspan="2">Wrap-Up</td><td colspan="2">Wrap-Up</td></tr>
<tr><td>6:00-8:00</td><td colspan="2"></td><td>Family Group</td><td colspan="2"></td></tr>
</table>

Shaded areas are times not billed to Medical Assistance.

Department of Health and Social Services
Division of Community Services
Office of Mental Health
March 20, 1992

STATE OF WISCONSIN

# MODEL INTERAGENCY TREATMENT PLAN

| **Name of Client:** Is Patient | **Interagency Team Developing and Implementing this Plan (include title indicating discipline):** |
|---|---|
| **Client Birthdate:** 7/15/75 | **1.** I.M. Primary, RN (day treatment) I. M. Primary |
| **Client M.A. Number:** 1234567890 | **2.** I.M. Manager, OT (day treatment) I. M. Manager |
| Date of This Plan: 2/19/92 | **3.** I.M. Doctor, PhD I. M. Doctor |
| **Plan review date:** 8/92 | **4.** I.M. Teacher (City School) I. M. Teacher |
| **Case Manager:** I.M. Manager | **5.** I.M. Psychiatrist, M.D. (psychiatrist) I. M. Psychiatrist |
| **Parent(s) or Primary Caregiver:** | **6.** |
| Be Patient, Father | **7.** |
| Was Patient, Mother | **8..** |
| | **9.** |
| | **10.** |
| | **11.** |
| | **12.** |
| | **Was parent or primary caregiver present? Yes No** |
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**PROBLEM SUMMARY: In the space provided below, describe the problems of the child and the family. Specify the elements of the problem which are to be treated.**

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| Is has experienced mood swings, depression, and suicidal ideation with periodic superficial cutting. Symptoms began in spring of 1990. |
| Attendance at school became a problem and grades dropped from As and Bs to Ds and Fs over the course of the following year. There was |
| also increasing conflict at home. Although she initially denied alcohol and drug use, more recently she has acknowledged significant substance |
| abuse which includes occasional blackouts. She was hospitalized in October 1991 and again in February 1992. Problems to be treated: |
| 1. Depression/mood swings; |
| 2. Substance abuse; |
| 3. Impaired family relationships. |
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**Please summarize in the spaces provided the element(s) and the methodology to be used by each system to treat this child (school, social services, mental health, health or the juvenile justice system), as applicable. For agencies not involved in treatment, put N/A in box.**

| **Mental Health Agency Response:** | **Short Term Goal (measurable):** Is will attend day treatment program and discuss issues in |
|---|---|
| While Is has made some | group 3 X week. Is will be able to identify three situations which lead to cutting behavior and |
| progress in expression of feelings and | three healthy responses. Is will be able to identify the definition of substance abuse and relate it |
| acknowledgement of substance abuse, | to her situation. |
| she has not shown the ability to | **Long Term Goal (measurable):** Is will remain abstinent from drugs and alcohol. Is will |
| function well outside a highly | cease cutting on herself as a response to problems. Is and her family will be able to talk about |
| structured setting. She appears | feelings and problem solve together. Is will become reinvolved in recreational activities. |
| unrealistic yet about the severity of | |
| her substance abuse. She needs to | **Plan (include frequency of intervention and team member responsible):** |
| develop better communication skills | Attend day treatment 5 days per week. (RN/OT/AODA counselor) |
| with therapists and family. | Attend 2 AA/NA/or Alateen meetings weekly. (OT will monitor) |
| | Family therapy and multiple family group weekly. (Ph.D.) |
| | Medication Management (M.D.) |
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| | **Measurable Results of Intervention at Time of Plan Review:** |
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| Social Services Agency Response: | Short Term Goal (measurable) |
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| | **Long Term Goal (measurable):** |
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| | **Plan (include frequency of intervention and team member responsible):** |
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| | **Measurable Results of Intervention at Time of Plan Review:** |
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| School Agency Response: | Short Term Goal (measurable) |
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| Patient is on a reduced schedule to | Attend all classes on a daily basis. Seek out staff assistance when she is having problems. |
| allow her to attend day treatment and | |
| to catch up slowly and not stress her | |
| at this time. She is still not attending | Long Term Goal (measurable): |
| all classes. | Resume full time schedule and level of achievement prior to when problems began (As and Bs). |
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| | Plan (include frequency of intervention and team member responsible): |
| | Is will be placed in special homeroom for recovering students. (Teacher) |
| | Is will attend recovery group at school. (School counselor) |
| | School will monitor attendance. (Teacher) |
| | Will have meeting with school psychologist 1 X wk. (School counselor) |
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| | Measurable Results of Intervention at Time of Plan Review: |
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| Juvenile Justice Agency Response: | Short Term Goal (measurable) |
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| | **Long Term Goal (measurable):** |
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| | **Plan (include frequency of intervention and team member responsible):** |
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| | **Measurable results of Intervention at Time of Plan Review:** |
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| Health Agency Response: | Short Term Goal (measurable) |
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| | **Long Term Goal (measurable):** |
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| | **Plan (include frequency of intervention and team member responsible):** |
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| | **Measurable Results of Intervention at Time of Plan Review:** |
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| **SERVICES RECOMMENDED BY TREATMENT TEAM:**<br>1. Day Treatment Program | **5.** |
| **2.** School Recovery Group | **6.** |
| **3.** | **7.** |
| **4.** | **8.** |

| **Program Discharge Criteria:** |
|---|
| **1. Is will be able to maintain 'no self harm' contracts between self and family (to be developed during family therapy).** |
| **2. Is will have a regular/consistent recovery program established.** |
| **3. Is will demonstrate regular, daily attendance at school.** |
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**Psychiatrist's Signature:**_____ **Date:**_____

**I (We) have read the foregoing treatment plan and give our consent to my (our) my child receiving the treatment outlined above. I (we) will agree to participate in the treatment intervention outlined above.**

**Parent(s)' or Primary Caregiver's Signature** J.M. Provider **Date:** mm/dd/yy

*file = Service\IATxPlan [E,Green]*

# CHILD AND ADOLESCENT FUNCTIONAL ASSESSMENT SCALE

| Is A. Patient | I.M. Primary | MMDDYY |
|---|---|---|
| Client's Name | Rater | Date |

**The CAFAS is used to assess a youth's functional impairment, rated as severe, moderate, mild or average. If any one item listed under category of impairment describes the youth's functioning, the youth qualifies for a rating in that category. You should indicate all items that apply in that category. Do this by circling the number to the right of the item description. Do not circle any items that apply in lower categories. Rate the youth's most severe level of dysfunction in the last month.**

1. **For each sub-scale begin your assessment by reviewing items in the SEVERE category. If any item describes the youth's functioning, circle all that apply in that category, and write the score "30" in the score box on the left.**

2. **If none of the items in the SEVERE category describe the youth, proceed to the MODERATE category. If none of the items in the MODERATE category describe the youth, proceed to the MILD category, and so on. If the youth is described by any of the items in a category, then that category will apply to the youth. Always start with the SEVERE CATEGORY AND PROGRESSIVELY PROCEED TO THE AVERAGE CATEGORY, STOPPING AT THE CATEGORY IF THE YOUTH IS DESCRIBED BY ANY ONE OF THE ITEMS IN THAT PARTICULAR CATEGORY.**

3. **If you believe that the youth should be rated in a category of impairment where no items are circled, write the score in the score box, circle the number corresponding to the "EXCEPTION" box, and explain the reason for your rating in the space labeled "Explanation...."**

| | **Severe**<br>Severe disruption or incapacitation<br>(30) | **Moderate**<br>Occasional major or frequent disruptions<br>(20) | **Mild**<br>Significant problems and/or distress<br>(10) | **Average**<br>No disruption of functioning<br>(0) |
|---|---|---|---|---|
| (1)<br>Role Performance<br>20 | Unable to maintain job, school, or family role because of impairment... 001<br>Extensive management by others required in order to be maintained in the home... 002<br>Expelled or equivalent from school... 003<br>Unable to meet even minimum requirements for behavior in classroom (either in regular or specialized classroom in public school or equivalent)... 004<br>Currently confined for legal violations... 005 | Persistent problems at work/school (e.g., frequently in trouble; at risk of expulsion; history of multiple expulsions or suspensions)... 007<br>Persistent failure (008) to meet usual expectations in family relations and/or behavior/responsibilities within home (may be at risk for placement out of home due to impairment)...<br>Currently at risk of confinement because of frequent or serious violations of law, delinquent behavior, running away, probation or parole... 009<br>Persistent problems in school due to extreme difficulty sustaining attention to tasks... 010 | Frequent problems at school/work due to lateness/absences/poor performance/failure to hand in work... 012<br>Frequently fails to meet expectations in family relations and/or in behavior/responsibilities within home... 013<br>Often disregards school rules... 014<br>Minor legal violations (no history of confinement)... 015 | Reasonably comfortable and competent in relevant roles... 017<br>Minor problems satisfactorily resolved... 018 |
| | EXCEPTION 006 | EXCEPTION 011 | EXCEPTION 016 | EXCEPTION 019 |
| | Explanation: | | | |

Could Not Score: 020

| | Severe<br>Severe disruption or incapacitation<br>(30) | Moderate<br>Occasional major or frequent disruptions<br>(20) | Mild<br>Significant problems and/or distress<br>(10) | Average<br>No disruption of functioning<br>(0) |
|---|---|---|---|---|
| (2)<br>Thinking<br><br>10 | Extreme distortion of coherent thought and language (may include bizarre play, incoherence, loosening of associations, flight of ideas)... 026<br><br>Frequent and/or disruptive delusions or hallucinations/can't distinguish fantasy from reality... 022<br><br>Pattern of short term memory loss/disorientation to time or place most of the time... 023<br><br>Inability to communicate with others and or marked abnormalities in nonverbal or verbal communication (e.g., echolalia, idiosyncratic language)... 024 | Frequent distortion of thinking (obsessions, mistrust, suspicions 026<br><br>Intermittent hallucinations that interfere with normal functioning... 027<br><br>Frequent confusion or evidence of short term memory loss... 028<br><br>Unable to comprehend consequences of behavior... 029<br><br>Evidence of persistent and excessive fantasy (e.g., daydreams, artwork, writing samples) with destructive and/or bizarre themes... delinquent behavior, running away, probation or parole... 030 | Occasional difficulty in communication or behavior due to thought distortions (e.g., obsessions, mistrust, suspicions... (032)<br><br>May express odd beliefs, excessive fantasy or, if older than eight years old, magical thinking... 033<br><br>Eccentric speech e.g., impoverished, digressive, vague)... 034<br><br>Unusual perceptual experiences not qualifying as hallucinations... 035 | Thought, as reflected by communication, is not disordered or eccentric... 037 |
| | EXCEPTION 025 | EXCEPTION 031 | EXCEPTION 036 | EXCEPTION 038 |
| | Explanation: | | | |

Could Not Score: 020

| | Severe<br>Severe disruption or incapacitation<br>(30) | Moderate<br>Occasional major or frequent disruptions<br>(20) | Mild<br>Significant problems and/or distress<br>(10) | Average<br>No disruption of functioning<br>(0) |
|---|---|---|---|---|
| (3)<br>Behavior Toward Others/Self<br>30 | Behavior consistently inappropriate or bizarre... 040<br>Behavior so disruptive or dangerous that harm to self or others is likely... 041<br>Expelled from family for reasons related to impairment... 042<br>Unable to form/ sustain any age-appropriate close relationships... 043<br>Severe destructiveness toward property (e.g., deliberate fire-setting; serious damage to community/school property)... 044 | Behavior frequently/ typically inappropriate and causing problems for self or others (e.g., promiscuity, fighting, destruction of property)... 046<br>Predominantly relates to others in an exploitative/manipulative manner (e.g., uses/cons others)... 047<br>Relationships frequently fraught with tension or conflict... 048<br>Characteristically poor judgement resulting in serious risk-taking... 049 | Quarrelsome or annoying, making life difficult for self or others... 051<br>Impulsiveness that is not affected by known consequences (e.g., disregards risk to health or expectations of others)... 052<br>Withdrawn or tends to be ignored by peers... 053<br>Difficulty in establishing/sustaining close relationships (e.g., predominantly age-inappropriate relationships; immature behavior leads to routine conflicts)... 054 | Relates satisfactorily to others... 056<br>Not impulsive, shows good judgement in life decisions... 057<br>Is able to establish/ sustain a normal range of age-appropriate relationships... 058 |
| | EXCEPTION 045 | EXCEPTION 050 | EXCEPTION 055 | EXCEPTION 059 |
| | Explanation: | | | |

Could Not Score 060

| | Severe<br>Severe Disruption or incapacitation<br>(30) | Moderate<br>Occasional major or frequent disruptions<br>(20) | Mild<br>Significant problems and/or distress<br>(10) | Average<br>No disruption of functioning<br>(0) |
|---|---|---|---|---|
| (4)<br><br>Moods/ Emotions<br><br>(Emotions = anxiety, depression, moodiness, fear, worry, irritability, tenseness, panic)<br><br>20 | Emotional 061 responses incongruous or inappropriate (unreasonable, excessive) most of the time...<br><br>Fears, phobias, 062 worries, or anxieties result in poor attendance at school (i.e., absent more than present) or marked social withdrawal...<br><br>Depression is 063 incapacitating at times (e.g., academically, socially) or is accompanied by suicidal intent... | Marked changes 065 in moods that are generally intense and abrupt...<br><br>Symptoms of distress (066) (depressed, sad, fearful or anxious) are pervasive and/or persistent (e.g., disrupts sleep, eating, concentration and/or activities of daily living or symptoms of worthlessness or irritability are pervasive and other symptoms are persistent (e.g., sleep, eating, etc.)<br><br>Emotional 067 blunting... | Often worried or 069 sad with some negative effect (e.g., recurrent nightmares)...<br><br>Disproportionate 070 expression of frustration, irritability or fear...<br><br>Notable emotional 071 restriction (i.e., has difficulty expressing strong emotions such as fear, hate, love)... | Feels normal distress, 073 but daily life is not disrupted...<br><br>Considers self 074 a "worthy person"...<br><br>Can express strong 075 emotions appropriately... |
| | EXCEPTION 064 | EXCEPTION 068 | EXCEPTION 072 | EXCEPTION 076 |
| | Explanation: | | | |

Could Not Score: 077

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| | Severe<br>Severe disruption or incapacitation<br>(30) | Moderate<br>Occasional major or frequent disruptions<br>(20) | Mild<br>Significant problems and/or distress<br>(10) | Average<br>No disruption of functioning<br>(0) |
|---|---|---|---|---|
| | These categories apply to youth of all ages | | | |
| (5)<br>Substance Use<br>(Substances = alcohol or drugs)<br><br>20 | Lifestyle centers on acquisition and use (e.g., preoccupied with thoughts or urges to use substances)... 078<br><br>Dependent on continuing use to maintain functioning (e.g., likely to experience withdrawal symptoms)... 079<br><br>Failing school or kicked out of school or work related to usage... 080<br><br>Frequently intoxicated or high (e.g., more than two times a week)... 081 | Uses in such a way as (084) to interfere with functioning (i.e., job, school, driving) in spite of potential serious consequences...<br><br>Gets into trouble because of usage (e.g., fights with family or friends, in an accident or injured, trouble with teachers, picked up by police, experiencing physical health problems due to use)... 085<br><br>High or intoxicated once a week... 086 | Infrequent excesses and only without serious consequences... 089<br><br>Regular usage (e.g., once a week) but without intoxication or being obviously high... 090 | No use of substances... 093<br><br>Has only "dried" themselves not use them... 094<br><br>Occasional use with no negative consequences... 095 |
| | If youth is 12 or younger, use these additional categories | | | |
| | For 12 years or younger, high or intoxicated once or twice a week... 082 | For 12 years or younger, use regularly (once a week) without intoxication and without becoming obviously high... 087 | For 12 years or younger, occasional use with no negative consequences... 091 | |
| | EXCEPTION 083 | EXCEPTION 088 | EXCEPTION 092 | EXCEPTION 096 |
| | Explanation: | | | |

Could Not Score: 097

**TOTAL SCORE FOR CATEGORIES 1 - 5**

100

ADDITIONAL COMMENTS:

CONTINUE ONTO NEXT PAGE

| | Severe<br>Severe disruption or incapacitation<br>(30) | Moderate<br>Occasional major or frequent disruptions<br>(20) | Mild<br>Significant problems and/or distress<br>(10) | Average<br>No disruption of functioning<br>(0) |
|---|---|---|---|---|
| (6)<br>Caregiver Resources: Basic Needs<br>○ | Unable to meet 098 child's needs for food, clothing, housing, transportation, medical attention or safety, such that severe risk to health or welfare is likely... | Frequent 100 problems meeting child's needs for food, housing, clothing, transportation, medical attention, or safety... | Occasional 102 problems meeting child's needs for food, housing, clothing, transportation, medical attention, or safety... | Able to obtain 104 or arrange for adequate meeting of all basic needs... |
| | EXCEPTION 099 | EXCEPTION 101 | EXCEPTION 103 | EXCEPTION 105 |
| | Explanation: | | | |

Could Not Score 106

| | | | | |
|---|---|---|---|---|
| (7)<br>Caregiver Resources: Family/ Social Support<br>○ | Sociofamilial setting 107 is potentially dangerous to the child due to lack of family resources required to meet the child's needs/demands...<br><br>Gross parental 108 impairment (e.g., psychosis, substance abuse, severe personality disorder, mental retardation)...<br><br>Frankly hostile and/or 109 rejecting sociofamilial setting...<br><br>Child is subjected to 110 sexual or physical abuse... | Child's developmental 112 needs cannot be adequately met because child's needs/developmental demands exceed family resources...<br><br>Marked impairment in 113 parental functioning, related to psychiatric illness, substance use, physical illness, or other impairing condition...<br><br>Persistent/severe 114 dysfunctional/discordant familial relationships (characterized by hostility, tension, and/or scapegoating, etc.)...<br><br>Family members are 115 insensitive, angry and/or resentful to the child...<br><br>Marked lack of 116 parental supervision or consistency in care... | Family not able to 118 provide adequate warmth, security or sensitivity relative to the child's needs. Support from other sources outside the immediate family are unable to compensate for this inadequacy...<br><br>Dysfunctional/ 119 discordant familial relationships (characterized by poor problem solving, poor communication, emotional insensitivity, role reversal, etc.). No other supports compensate for this deficit...<br><br>Family not able to 120 provide adequate supervision or consistency in care over time relative to the child's needs. No other supports compensate for this deficit... | Family is 122 sufficiently warm, secure, and sensitive to the child's needs...<br><br>Parental supervision 123 in consistent and appropriate...<br><br>Even though there are 124 temporary problems in providing adequate support to the child, there is compensation from the wider social support system. |
| | EXCEPTIONAL 111 | EXCEPTIONAL 117 | | |
| | Explanation: | | | |

Could Not Score: 126

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**TOTAL SUB-SCORE FOR CATEGORIES 6 and 7 ONLY**

| |
|---|
| 0 |

The Family/Social Support Sub-Scale contains ideas and wording adapted from a measure developed by Setterberg, Shaffer, Williams, and Spitzer.